TRICARE Prime Change Form Instructions

All Primary Care Manager change requests for a new Primary Care Manager (PCM) within the Military Hospital or from a Military PCM to a civilian PCM must be pre-approved according to the Military Treatment Facility Commander guidelines.

Complete the Sponsor Information Section for all change requests.

1. Sponsor's Name – Last name, First name, Middle initial.
2. Sponsor's Social Security Number.
3. Sponsor's Address – Street/P.O. Box, Apt. Number, City, County, State, Zip Code.
4. Sponsor's Birthdate – Month, Day, Year.
5. Is Sponsor Active Duty – Check the appropriate box.
6. Active Duty Sponsor's Pay Grade – Check the appropriate box.
7. Is Sponsor Enrolling, Deceased, Retiring, or Retired – Check the appropriate box and list date.
8. List Sponsor's Phone Numbers – Sponsor (Home/Work), Spouse (Work).
9. List Sponsor's Unit of Assignment.
10. Complete only if Retired and enrolling or changing PCM. State Sponsor's first choice for a PCM. A Military Treatment Facility team or civilian physician MUST be selected from a TRICARE Provider Directory. List Military Treatment Facility team name or civilian PCM name.
11. List Retired Sponsor's second choice for a PCM (MTF team or civilian PCM). A Military Treatment Facility team or a civilian physician MUST be selected from your TRICARE Provider Directory. HMHS will assign a PCM if your first and second choice cannot be honored.

New Family Member/PCM Change/Address Change Section

Complete for each family member for each new enrollee, each PCM change and/or each address change. With new family member enrollments or PCM changes, please be aware that all family members, including newborns, must be enrolled in DEERS prior to enrolling in Prime. Application processing will be delayed if your family information is incomplete or does not match the DEERS file.

12. State Family Member's Name – Last name, First name, Middle initial for family members enrolling in TRICARE Prime.
    State Family Member's Social Security Number.
    State Family Member's Gender.
    State Family Member's Address – Street/P.O. Box, Apt. Number, City, County, State, Zip Code.
    State Family Member's Phone Number.
    State Family Member's first choice for a Primary Care Manager (PCM) from the TRICARE Provider Directory.
    State Family Member's Birthdate – Month, Day, Year.
    State Family Member's Relationship to Sponsor.
    State Family member's second choice for a PCM (MTF team or civilian PCM) from the TRICARE Provider Directory.

Disenrollment Section

13. State Disenrolling Family Member's Name – Last name, First name, Middle initial.
    State Family Member's Reason for Disenrollment – Check the appropriate box.
    State Requested Effective Date of Disenrollment.
    Obtain approval if required.

Payment Section

Complete the following section if any additional payment is due as a result of adding a new family member to an existing single enrollment. Retirees and their family members wishing to add a new family member in Prime must enclose a **non-refundable** enrollment fee. The enrollment fee must be paid at the time of the change in order to prevent processing delays. Your annual or quarterly payment will be prorated and applied toward a new 12-month enrollment period. Your completed application form will be processed and a Prime enrollment card will be mailed to each eligible family member. The effective date of membership will be indicated on each card.

14. State whether you would like to pay annually or quarterly – Check the appropriate box.
    Please indicate amount enclosed or to be charged.
    State your method of payment – Check the appropriate box. If paying by credit card, a signature is required. Do not send post-dated checks.

ENROLLMENT FEES	
ACTIVE DUTY FAMILY MEMBERS None	RETIREES AND THEIR FAMILIES Individual: $230 annually or $57.50 per quarter Family: $460 annually or $115 per quarter

Signature and Forwarding Section

15. Sign, indicate relationship to sponsor and date.
    Mail completed form to the address indicated, or take the completed form to your local TRICARE Service Center.

AGENCY DISCLOSURE STATEMENT: Public reporting of this collection of information is estimated to average 15 minutes per application, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to the Department of Defense, to Washington Headquarters Services, Directorate of Information Operations and Reports, 1216 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4802; and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington DC 20508. PLEASE DO NOT RETURN YOUR APPLICATION TO EITHER OF THESE ADDRESSES. SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION SHEET.

PRIVACY ACT STATEMENT: (1) 44 USC 8101; 10 USC 1079 ABD 1086, 88 USC 4318; EO 9397. (2) Purpose: To evaluate for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (82 CFR, Part 199.17). (3) Uses: Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); to the Department of Justice for representation of the Secretary of Defense in civil action; and to Congressional Offices in response to inquiries made in the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program. (4) Disclosure: Voluntary; however, failure to provide information will result in denial of enrollment.

Retrieve Data | Reset Radio Buttons | Reset Form

TRICARE Prime Change Form

Check appropriate box for all that apply

- Address Change
  Effective Date of Move ______
- New Family Member
- Primary Care Manager Change
  Reason for Change ______
- Disenrollment
  Commander or Lead Agent Approval Signature/Date

SPONSOR INFORMATION

1. Sponsor's Name Last First MI
2. Sponsor's Social Security Number
3. Street or P.O. Box Apt. No. City County State Zip Code
4. Birthdate Mo. Day Yr.
5. Active Duty? Yes No
6. Active Duty Sponsor's Pay Grade E1 - E4 E5 and above
7. Is Sponsor: Deceased ______ Date Enrolling Retiring ______ Date Retired ______ Date
8. Sponsor's Phone Home Work Spouse Work
9. Active Duty Unit of Assignment — If sponsor is active duty or deceased, skip to #12
10. Retired Sponsor's 1st Choice - PCM (MTF Team or Civilian Physician)* **Must complete to enroll** (Refer to the Tricare Provider Directory for guidance)
11. Retired Sponsor's 2nd Choice - PCM (MTF Team or Civilian Physician)* **Must complete to enroll** (2nd choice will be honored if your first choice is full)

NEW FAMILY MEMBER/PCM CHANGE/ADDRESS CHANGE

12. Name Last First MI | Social Security Number | Sex M / F
Street or P.O. Box Apt. No. City County State Zip Code Phone
Family Member's 1st Choice - PCM (MTF Team or Civilian Physician)* **Must complete to enroll** | Family Member Birthdate | Family Relationship to Sponsor
Family Member's 2nd Choice - PCM (MTF Team or Civilian Physician)* **Must complete to enroll** (2nd choice will be honored if your first choice is full)

12. Name Last First MI | Social Security Number | Sex M / F
Street or P.O. Box Apt. No. City County State Zip Code Phone
Family Member's 1st Choice - PCM (MTF Team or Civilian Physician)* **Must complete to enroll** | Family Member Birthdate | Family Relationship to Sponsor
Family Member's 2nd Choice - PCM (MTF Team or Civilian Physician)* **Must complete to enroll** (2nd choice will be honored if your first choice is full)

12. Name Last First MI | Social Security Number | Sex M / F
Street or P.O. Box Apt. No. City County State Zip Code Phone
Family Member's 1st Choice - PCM (MTF Team or Civilian Physician)* **Must complete to enroll** | Family Member Birthdate | Family Relationship to Sponsor
Family Member's 2nd Choice - PCM (MTF Team or Civilian Physician)* **Must complete to enroll** (2nd choice will be honored if your first choice is full)

DISENROLLMENTS

13. Last Name First MI | Reason for Disenroll: Moved PCS Orders CHAMPUS Ineligible Retirement Other: (May Require Approval) | Requested Effective Date
Last Name First MI | Reason for Disenroll: Moved PCS Orders CHAMPUS Ineligible Retirement Other: (May Require Approval) | Requested Effective Date
Last Name First MI | Reason for Disenroll: Moved PCS Orders CHAMPUS Ineligible Retirement Other: (May Require Approval) | Requested Effective Date
Last Name First MI | Reason for Disenroll: Moved PCS Orders CHAMPUS Ineligible Retirement Other: (May Require Approval) | Requested Effective Date

PAYMENT

14. Payment Option Annual Quarterly
Amount enclosed or to be charged $ ______ (Not applicable for Active Duty Families)
Method of Payment Attached (Must pay fees at time of enrollment) Check # ______
Type of card VISA MasterCard American Express Discover Money Order # 123,413
Credit card number ____ – ____ – ____ – ____ Expiration Date ______
Your signature authorizes the credit card company to charge the fee to the card number above.
Signature ______

SIGNATURE

15. Please review the Agency Disclosure and Privacy Act statement on the reverse side of this application before signing.

Signature ______ Relationship to Sponsor ______ Date ______

When complete, mail application to: Humana Military Healthcare Services, Inc.
P.O. Box 740061
Louisville, KY 40201-7461

Authority: 10 U.S.C. Chapter 55, CHAMPUS PRINCIPAL PURPOSES: Enrollment in the TRICARE Prime program. ROUTINE USES: Verify eligibility and produce enrollment cards. DISCLOSURE IS VOLUNTARY Failure to provide the information could result in denial of reimbursement under the CHAMPUS program.

Please return this copy,

Save Data | Print | Email Form